State: *Arkansas* ***Filing Company:*** *Government Personnel Mutual Life Insurance Company*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *MIB 2013 Authorization Change*
Project Name/Number: *Policy Change Request/01.06 PCR*

Filing at a Glance

Company:	Government Personnel Mutual Life Insurance Company
Product Name:	MIB 2013 Authorization Change
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	10/15/2012
SERFF Tr Num:	GPML-128702232
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	01.06 PCR (0912)
Implementation Date Requested:	On Approval
Author(s):	Linda Boydston, Norma Castillo
Reviewer(s):	Linda Bird (primary)
Disposition Date:	10/17/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Government Personnel Mutual Life Insurance Company*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *MIB 2013 Authorization Change*
Project Name/Number: *Policy Change Request/01.06 PCR*

General Information

Project Name: Policy Change Request
Project Number: 01.06 PCR
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Linda Boydston

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/17/2012
State Status Changed: 10/17/2012
Created By: Norma Castillo
Corresponding Filing Tracking Number:

Filing Description:

This filing contains no unusual or controversial items from normal Company or industry standards.

Application form 01.06 PCR(0912) is being submitted for your approval. It will replace the previously approved form shown below.

1. 01.06 PCR(1088) , approved 11/06/1989.

The form was created in order to comply with the MIB 2013 Authorization change by adding, "I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB" to the authorization section in the application. It will be used to request changes to a policy subsequent to the issue of the policy.

A marked up copy of the differences between 01.06 PCR(1088) and 01.06 PCR (0912) is attached under the Supporting Document for reference.

These forms are in final print format; however, we reserve the right to change the format due to technological advances.

Company and Contact

Filing Contact Information

Norma Castillo, Regulatory Filing Assistant
2211 N.E. Loop 410
P.O. Box 659567
San Antonio, TX 78217

anc@gpmlife.com
800-938-4765 [Phone] 2724 [Ext]
210-357-6722 [FAX]

Filing Company Information

Government Personnel Mutual Life Insurance Company
2211 N.E. Loop 410
P.O. Box 659567
San Antonio, TX 78217
(800) 938-4765 ext. 2814[Phone]

CoCode: 63967
Group Code: 4712
Group Name:
FEIN Number: 74-0651020

State of Domicile: Texas
Company Type: LAH
State ID Number:

State: *Arkansas* ***Filing Company:*** *Government Personnel Mutual Life Insurance Company*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *MIB 2013 Authorization Change*
Project Name/Number: *Policy Change Request/01.06 PCR*

Filing Fees

Fee Required? Yes
Fee Amount: $100.00
Retaliatory? Yes
Fee Explanation: Texas retaliatory fee is $100 for approval.
Per Company: No

Company	Amount	Date Processed	Transaction #
Government Personnel Mutual Life Insurance Company	$100.00	10/15/2012	63872804

SERFF Tracking #:	*GPML-128702232*	***State Tracking #:***		***Company Tracking #:***	*01.06 PCR (0912)*

State:	*Arkansas*	***Filing Company:***	*Government Personnel Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB 2013 Authorization Change*		
Project Name/Number:	*Policy Change Request/01.06 PCR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/17/2012	10/17/2012

SERFF Tracking #:	*GPML-128702232*	***State Tracking #:***		***Company Tracking #:***	*01.06 PCR (0912)*

State:	*Arkansas*	***Filing Company:***	*Government Personnel Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB 2013 Authorization Change*		
Project Name/Number:	*Policy Change Request/01.06 PCR*		

Disposition

Disposition Date: 10/17/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Supporting Document	Marked Up copy of 01.06 PCR (1088)		Yes
Form	Policy Change Request Application		Yes

SERFF Tracking #:	*GPML-128702232*	***State Tracking #:***		***Company Tracking #:***	*01.06 PCR (0912)*

State:	*Arkansas*	***Filing Company:***	*Government Personnel Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB 2013 Authorization Change*		
Project Name/Number:	*Policy Change Request/01.06 PCR*		

Form Schedule

Lead Form Number: 01.06 PCR (0912)

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		01.06 PCR (0912)	AEF	Policy Change Request Application	Initial:	59.200	0106 2012.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM") [San Antonio, Texas 78265-9567]

POLICY CHANGE REQUEST

Telephone # ( ) _____

Policy Number	Insured/Proposed Insured to whom Change Relates	Policyowner, if other than Insured		
Mailing Address	Number and Street	City	State	Zip Code
Insured's Employer	Insured's Occupation	☐ Insured's ☐ Payor's	Paygrade	Branch

A. Complete for all persons to be considered for insurance, including Primary Insured, if applicable.

Full Name First Middle Last	Relationship to Insured	Sex M or F	Date of Birth Mo. Day Year	Birthplace State or Country	Height Ft. / In.	Weight Lbs.	Life Ins. In Force
			- -				
			- -				
			- -				
			- -				
			- -				

B. Change/Action Requested

☐ Reinstate Policy ☐ Redate Policy to _____/01/_____

☐ Add Benefit(s) ☐ WPD/WCI ☐ ADB $ _____

☐ CIR/CBR $ _____ ☐ SIR/OIR $ _____ ☐ FIR _____ units

☐ Other

☐ Convert from . . . Plan _____ Amount $_____
to . . . Plan _____ Amount $ _____

Conversion to be effective first day of _____, 20 _____

Benefit Options: If Universal Life, Death Benefit Option ☐ A ☐ B

☐ WPD/WCI ☐ ADB $ _____ ☐ SIR/OIR $ _____
☐ CIR/CBR $ _____ ☐ Other _____
☐ Div Opt: ☐ Cash ☐ Reduce Prem ☐ Pd. Up Adds ☐ Accum

Premium Mode: ☐ Annual ☐ Semiannual ☐ PAC ☐ MA ☐ FEA
☐ Auto Premium Loan Provision hereby elected, if available.

The Beneficiary Designation of the new policy will be . . .

*Class	Name	Age	Relationship
1			

*Class 1–Primary, Class 2–Contingent, etc.

☐ Flexible Premium Adjustable Life Changes:
☐ Change Death Benefit Option to ☐ Option A ☐ Option B
☐ Increase Specified Amount of Policy to $ _____

☐ Reduce/Remove Rating ☐ Change Div. Opt. to Paid-Up Add's

☐ Matured Endowment Option _____ (Insurability required.)

☐ Other _____

C. Complete only if evidence of insurability is required.

	Yes	No
1. Is the insurance applied for intended to replace any existing insurance or annuity contract?	☐	☐
2. Does any Proposed Insured have any other application for life or health insurance pending?	☐	☐
3. Has any person proposed for coverage:		
(a) ever had an application for life or health insurance declined, rated, or modified?	☐	☐
(b) engaged in vehicle racing, underwater sport, hang gliding, parachuting, mountain climbing, or cave exploration in the past 5 years?	☐	☐
(c) any intention of living outside the United States and Canada in the next 2 years?	☐	☐
(d) been convicted of 3 or more moving violations, or had a driver's license suspended or revoked, in the last 3 years?	☐	☐

Please provide full explanations of any "yes" answers above:

_____
_____
_____
_____
_____
_____
_____

	Yes	No
4. Has any Proposed Insured flown as a pilot or crew member in the past 5 years; or any plans to do so in the future? (If so, provide details below.)	☐	☐

Person to Whom Answers Apply _____

Purpose of Flights:_____

Type(s) of Aircraft _____

Duties on Board ☐ Pilot ☐ Other _____

Total Hours Flown _____ Past 12 Months _____

12-24 Months Ago _____ Next 12 Months _____

01.06 PCR (0912) (0912)

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM") [San Antonio, Texas 78265-9567]

Underwriting Pre-Notices (Agent: Detach and give to Proposed Insured/Applicant)

NOTICE OF INSURANCE INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for Insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your right is available upon request.

INVESTIGATIVE CONSUMER REPORTS: As part of the underwriting process, we may request an investigative consumer report from a consumer reporting agency for the purpose of obtaining information about your character, reputation, and mode of living, through personal interviews with your friends, neighbors, and associates. You may ask for a personal interview with the consumer reporting agency in connection with any investigative consumer report which may be prepared. You are also entitled, upon written request pursuant to law, to be informed of the nature and scope of the investigation and to receive a copy of the report.

For further information, write: [Chief Underwriter, GPM Life, PO Box 659567, San Antonio, Texas 78265-9567]

D. Physical Data. (Complete only if evidence of insurability is required.)

1. Does any person proposed for coverage use tobacco in any form? ☐ Yes ☐ No (If "yes", describe tobacco use below.)
   Name _____ ☐ Cigarettes ____ packs per day ☐ Cigars ☐ Pipe ☐ Chewing or other "smokeless" tobacco
   Name _____ ☐ Cigarettes ____ packs per day ☐ Cigars ☐ Pipe ☐ Chewing or other "smokeless" tobacco
2. Is any person proposed for coverage a past user of tobacco? ☐ Yes ☐ No (If "yes", describe tobacco use below.)
   Name _____ Describe past use of tobacco _____ Month/Year quit _____
   Name _____ Describe past use of tobacco _____ Month/Year quit _____

	Yes	No	
3. Has any Proposed Insured ever had or been treated for:			Who? When? Complete Explanation/Doctors, Hospitals
(a) high blood pressure, chest pain, heart attack, abnormal heart beat, murmur, stroke, or any circulatory system disorder?	☐	☐	
(b) cancer, Hodgkin's disease, leukemia, or any tumor or polyp?	☐	☐	
(c) epilepsy, convulsions, severe headache, paralysis, nervous breakdown, psychosis, or any mental or nervous disorder?	☐	☐	
(d) AIDS (Acquired Immune Deficiency Syndrome)?	☐	☐	
4. In the past 10 years, has any Proposed Insured had or been treated for:			Who? When? Complete Explanation/Doctors, Hospitals
(a) diabetes, anemia, polycythemia, hemophilia; or any disorder or enlargement of any gland, including lymph glands?	☐	☐	
(b) persistent fever, cough, diarrhea, weakness, or infection?	☐	☐	
(c) asthma, bronchitis, emphysema, tuberculosis, pneumonia, or any infection or other disorder of the respiratory system?	☐	☐	
(d) ulcer, gastritis, colitis, hepatitis, cirrhosis, pancreatitis, or any disorder of liver, gall bladder or intestine?	☐	☐	
(e) any disorder of the kidneys, bladder, prostate, reproductive organs, or breasts, or any sexually transmitted disease?	☐	☐	
(f) any disorder of the back, spine, bones, joints, or muscles?	☐	☐	
(g) dependency on or abuse of alcohol or any drug?	☐	☐	
5. Within the past 5 years has any Proposed Insured:			Who? When? Complete Explanation/Doctors, Hospitals
(a) claimed benefits for any injury or sickness?	☐	☐	
(b) been hospitalized or received medical advice, surgery, medication or other treatment for any reason not already explained?	☐	☐	
6. Within the past year, has the weight of any Proposed Insured changed 10 pounds or more? (For children under 16 report only loss.)	☐	☐	Who? When? Complete Explanation/Doctors, Hospitals

AGREEMENT: I (each undersigned) represent that all of the answers written in this form are true and complete to the best of my knowledge and belief. It is agreed that: (1) This form will be relied on by GPM as the basis of any policy or amended policy that may be issued on it. (2) No agent, broker, or medical examiner can accept risk, make or change contracts, or waive any of GPM's rights or requirements. Only an authorized officer of GPM can do these things. (3) If the change requires proof of insurability, it will take effect on the "request date" if and only if two conditions are met. (The "request date" is the later of the date of this form or the date of any required medical exam.) The two requirements that must be met are that: (a) all persons for whom proof of insurability is required must be acceptable as standard risks under GPM's rules, limits, and underwriting standards; and (b) any money required to effect the change is submitted with this form. (4) If the change does not require proof of insurability, it will take effect when this form and any required money are received in the Home Office. (5) Acceptance of a policy or amended policy issued on this form will ratify any changes that may be noted in the box for "Home Office Endorsements." But where the law requires, written consent will be obtained for changes in this form.

AUTHORIZATION TO OBTAIN INFORMATION: For underwriting and claim purposes, I (each of the undersigned) authorize any doctor, hospital

AGENT: To your knowledge, will the insurance being applied for replace any existing life insurance or annuity? ☐ Yes ☐ No

Home Office Endorsements	Signed at (City, State) X	Signature of Primary Insured (If under 16, parent or legal guardian) X
	Date Signed X	Signature of Spouse Insured X
	Signature of Witness X	Signature of Owner, if not Insured X

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM") -[San Antonio, Texas 78265-9567]

MEDICAL INFORMATION BUREAU, INC. Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

We, or our reinsurer(s) may also release information in our file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

SERFF Tracking #:	*GPML-128702232*	***State Tracking #:***	***Company Tracking #:*** *01.06 PCR (0912)*

State:	*Arkansas*	***Filing Company:***	*Government Personnel Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB 2013 Authorization Change*		
Project Name/Number:	*Policy Change Request/01.06 PCR*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability Certification-signed.pdf Regulation 19.pdf Regulation 49.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
Memorandum of Variability.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Marked Up copy of 01.06 PCR (1088)		
Comments:			
Attachment(s):			
01.06 (1088)-marked up.pdf			

02AR

ARKANSAS

SUBJECT - Individual Life ___X___ Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER	FLESCH SCORE
01.06 PCR (0912)	**59.2**

This is to certify that the above referenced form has achieved a Flesch Reading Ease Score, as indicated, and complies with the requirements of Arkansas Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Sean Staggs, FSA, MAAA
Assistant Vice President & Associate Actuary

AR certification1

ARKANSAS

SUBJECT - Individual Life ___X___ Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER

01.06 PCR (0912)

This submission meets the provisions of Rule and Regulation 19, "Unfair sex discrimination in the sale of insurance" as well as all applicable requirements of this Department.

C. Alan Ferguson
Senior VP, General Counsel
& Secretary

AR certification3

ARKANSAS

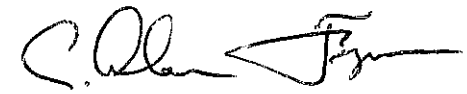
SUBJECT - Individual Life ___X___ Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER

01.06 PCR (0912)

On behalf of Government Personnel Mutual Life Insurance Company, I hereby certify that the company is in compliance with Regulation 49 in that we will issue a Life and Health notice to each policy owner.



C. Alan Ferguson
Senior VP, General Counsel
& Secretary

Memorandum of Variability
Explanation of Variable Statements and Fields
For Government Personnel Mutual Life Insurance Company
Form 01.06 PCR (0912)

Each variable section, statement or field is denoted by [brackets]. The explanations below follow the order in which the variable fields appear in the form.

Variable Statements/Fields	*How or When Used*
Page 1	
1. [P.O. Box 659567, San Antonio, TX 78265-9567]	This is the company's address
2. [866-692-6901 (TTY 866-346-3642]	This is MIB's phone number
3. [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734]	This is MIB's address
4. [www.mib.com]	This is MIB's webpage address

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM") San Antonio, Texas 78265-9567

POLICY CHANGE REQUEST

Telephone # ( ) _____

Policy Number	Insured/Proposed Insured to whom Change Relates	Policyowner, if other than Insured		
Mailing Address	Number and Street	City	State	Zip Code
Insured's Employer	Insured's Occupation	☐ Insured's ☐ Payor's	Paygrade	Branch

A. Complete for all persons to be considered for insurance, including Primary Insured, if applicable.

Full Name First Middle Last	Relationship to Insured	Sex M or F	Date of Birth Mo. Day Year	Birthplace State or Country	Height Ft. / In.	Weight Lbs.	Life Ins. In Force
			- -				
			- -				
			- -				
			- -				
			- -				

B. Change/Action Requested

☐ Reinstate Policy ☐ Redate Policy to _____/01/_____

☐ Add Benefit(s) ☐ WPD/WCI ☐ ADB $ _____

☐ CIR/CBR $ _____ ☐ SIR/OIR $ _____ ☐ FIR _____ units
☐ Other

☐ Convert from . . . Plan _____ Amount $_____
to . . . Plan _____ Amount $ _____

Conversion to be effective first day of _____, 20 _____

Benefit Options: If UniVersatile, Death Benefit Option ☐ A ☐ B

☐ WPD/WCI ☐ ADB $ _____ ☐ SIR/OIR $ _____
☐ CIR/CBR $ _____ ☐ Other _____
☐ Div Opt: ☐ Cash ☐ Reduce Prem ☐ Pd. Up Adds ☐ Accum

Premium Mode: ☐ Annual ☐ Semiannual ☐ PAC ☐ MA ☐ FEA
☐ Auto Premium Loan Provision hereby elected, if available.

The Beneficiary Designation of the new policy will be . . .

*Class	Name	Age	Relationship
1			

*Class 1–Primary, Class 2–Contingent, etc.

☐ Flexible Premium Adjustable Life Changes:
☐ Change Death Benefit Option to ☐ Option A ☐ Option B
☐ Increase Specified Amount of Policy to $ _____

☐ Reduce/Remove Rating ☐ Change Div. Opt. to Paid-Up Add's
☐ Matured Endowment Option _____ (Insurability required.)
☐ Other _____ 01.06 (PCR)(0912)

~~01.06 (PCR) (1088)~~

C. Complete only if evidence of insurability is required.

	Yes	No
1. Is the insurance applied for intended to replace any existing insurance or annuity contract?	☐	☐
2. Does any Proposed Insured have any other application for life or health insurance pending?	☐	☐
3. Has any person proposed for coverage:		
(a) ever had an application for life or health insurance declined, rated, or modified?	☐	☐
(b) engaged in vehicle racing, underwater sport, hang gliding, parachuting, mountain climbing, or cave exploration in the past 5 years?	☐	☐
(c) any intention of living outside the United States and Canada in the next 2 years?	☐	☐
(d) been convicted of 3 or more moving violations, or had a driver's license suspended or revoked, in the last 3 years?	☐	☐

Please provide full explanations of any "yes" answers above:

_____
_____
_____
_____
_____
_____
_____
_____

	Yes	No
4. Has any Proposed Insured flown as a pilot or crew member in the past 5 years; or any plans to do so in the future? (If so, provide details below.)	☐	☐

Person to Whom Answers Apply _____

Purpose of Flights: _____

Type(s) of Aircraft _____

Duties on Board ☐ Pilot ☐ Other _____ (0912)

Total Hours Flown _____ Past 12 Months _____

12-24 Months Ago _____ Next 12 Months _____

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM") - San Antonio, Texas 78265-9567
Underwriting Pre-Notices (Agent: Detach and give to Proposed Insured/Applicant)

NOTICE OF INSURANCE INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for Insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your right is available upon request.

INVESTIGATIVE CONSUMER REPORTS: As part of the underwriting process, we may request an investigative consumer report from a consumer reporting agency for the purpose of obtaining information about your character, reputation, and mode of living, through personal interviews with your friends, neighbors, and associates. You may ask for a personal interview with the consumer reporting agency in connection with any investigative consumer report which may be prepared. You are also entitled, upon written request pursuant to law, to be informed of the nature and scope of the investigation and to receive a copy of the report.

For further information, write: Chief Underwriter, GPM Life, PO Box 659567, San Antonio, Texas 78265-9567

D. Physical Data. (Complete only if evidence of insurability is required.)

1. Does any person proposed for coverage use tobacco in any form? ☐ Yes ☐ No (If "yes", describe tobacco use below.)
   Name _____ ☐ Cigarettes ____ packs per day ☐ Cigars ☐ Pipe ☐ Chewing or other "smokeless" tobacco
   Name _____ ☐ Cigarettes ____ packs per day ☐ Cigars ☐ Pipe ☐ Chewing or other "smokeless" tobacco
2. Is any person proposed for coverage a past user of tobacco? ☐ Yes ☐ No (If "yes", describe tobacco use below.)
   Name _____ Describe past use of tobacco _____ Month/Year quit _____
   Name _____ Describe past use of tobacco _____ Month/Year quit _____

	Yes	No	Who? When? Complete Explanation/Doctors, Hospitals
3. Has any Proposed Insured ever had or been treated for:			
(a) high blood pressure, chest pain, heart attack, abnormal heart beat, murmur, stroke, or any circulatory system disorder?	☐	☐	
(b) cancer, Hodgkin's disease, leukemia, or any tumor or polyp?	☐	☐	
(c) epilepsy, convulsions, severe headache, paralysis, nervous breakdown, psychosis, or any mental or nervous disorder?	☐	☐	
(d) AIDS (Acquired Immune Deficiency Syndrome)?	☐	☐	
4. In the past 10 years, has any Proposed Insured had or been treated for:			Who? When? Complete Explanation/Doctors, Hospitals
(a) diabetes, anemia, polycythemia, hemophilia; or any disorder or enlargement of any gland, including lymph glands?	☐	☐	
(b) persistent fever, cough, diarrhea, weakness, or infection?	☐	☐	
(c) asthma, bronchitis, emphysema, tuberculosis, pneumonia, or any infection or other disorder of the respiratory system?	☐	☐	
(d) ulcer, gastritis, colitis, hepatitis, cirrhosis, pancreatitis, or any disorder of liver, gall bladder or intestine?	☐	☐	
(e) any disorder of the kidneys, bladder, prostate, reproductive organs, or breasts, or any sexually transmitted disease?	☐	☐	
(f) any disorder of the back, spine, bones, joints or muscles?	☐	☐	
(g) dependency on or abuse of alcohol or any drug?	☐	☐	
5. Within the past 5 years has any Proposed Insured:			Who? When? Complete Explanation/Doctors, Hospitals
(a) claimed benefits for any injury or sickness?	☐	☐	
(b) been hospitalized or received medical advice, surgery, medication or other treatment for any reason not already explained?	☐	☐	
6. Within the past year, has the weight of any Proposed Insured changed 10 pounds or more? (For children under 16 report only loss.)	☐	☐	Who? When? Complete Explanation/Doctors, Hospitals

AGREEMENT: I (each undersigned) represent that all of the answers written in this form are true and complete to the best of my knowledge and belief. It is agreed that: (1) This form will be relied on by GPM as the basis of any policy or amended policy that may be issued on it. (2) No agent, broker, or medical examiner can accept risk, make or change contracts, or waive any of GPM's rights or requirements. Only an authorized officer of GPM can do these things. (3) If the change requires proof of insurability, it will take effect on the "request date" if and only if two conditions are met. (The "request date" is the later of the date of this form or the date of any required medical exam.) The two r… or whom proof of insurability is required must be acceptable as standard risks under GPM's rul… y required to effect the change is submitted with this form. (4) If the change does not require pr… y required money are received in the Home Office. (5) Acceptance of a policy or amended poli… e noted in the box for "Home Office Endorsements." But where the law requires, written consent will be obtained for changes in this form.

I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

AUTHORIZATION TO OBTAIN INFORMATION: For underwriting and claim purposes, I (each of the undersigned) authorize any doctor, hospital other health care provider; insurer, reinsurer the MIB, Inc., or consumer reporting agency having information as to the mental or physical health, occupation, avocations, other insurance, character, habits, driving record, finances, or age of me or my minor children to give such information to Government Personnel Mutual Life Insurance Company ("GPM") or its reinsurer(s). I further authorize all said sources, except the MIB, Inc. to give such information to any agent or insurance support organizations acting for GPM or its reinsurer(s). Any information obtained may be released by GPM to its reinsurer(s), the MIB, Inc., or other persons or organizations performing business or legal services in connection with my application or claim. This authorization will be valid for 30 months; a copy will be as valid as the original. I know that I may obtain a copy of it. I acknowledge receipt of a notice regarding "Insurance Information Practices", "Investigative Consumer Reports", and "MIB Inc." from GPM.

AGENT: To your knowledge, will the insurance being applied for replace any existing life insurance or annuity? ☐ Yes ☐ No

Home Office Endorsements	Signed at (City, State) X	Signature of Primary Insured (If under 16, parent or legal guardian) X
	Date Signed X	Signature of Spouse Insured X
	Signature of Witness X	Signature of Owner, if not Insured X

Please contact MIB at 866-692-6901 (TTY 866-346-3642).

01.06 (PCR) (1088)

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM") - San Antonio, Texas 78265-9567

MEDICAL INFORMATION BUREAU, INC. Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bure… MIB …on request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, ~~the Bureau~~ will arrange disclosure of any information it may have in your file. ~~(Medical information will be disclosed only to your attending physician.)~~ If you question the accuracy of information in ~~the Bureau's~~ file, you may contact ~~the Bureau~~ and seek a correction on accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of ~~the Bureau's~~ information office is ~~Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.~~

50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com

We, or our reinsurer(s) may also release information in our file to other life insurance companies t… to whom a claim for benefits may be submitted.

~~01.06 (PCR) (1088)~~ 01.06 PCR (0912)

(0912)